Complete Summary

GUIDELINE TITLE

Postnatal depression and puerperal psychosis. A national clinical guideline.

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Postnatal depression and puerperal psychosis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Jun. 28 p. (SIGN publication; no. 60). [171 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline was issued in 2002 and will be kept under review as new evidence becomes available.

Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- On December 8, 2005, the U.S. Food and Drug Administration (FDA) has determined that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations. At the FDA's request, the manufacturer has changed paroxetine's pregnancy category from C to D and added new data and recommendations to the WARNINGS section of paroxetine's prescribing information. FDA is awaiting the final results of the recent studies and accruing additional data related to the use of paroxetine in pregnancy in order to better characterize the risk for congenital malformations associated with paroxetine.

  Physicians who are caring for women receiving paroxetine should alert them to the potential risk to the fetus if they plan to become pregnant or are currently in their first trimester of pregnancy. Discontinuing paroxetine therapy should be considered for these patients. Women who are pregnant, or

planning a pregnancy, and currently taking paroxetine should consult with their physician about whether to continue taking it. Women should not stop the drug without discussing the best way to do that with their physician. See the FDA Web site for more information.

- On September 27, 2005, GlaxoSmithKline (GSK) and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paxil and Paxil CR Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy. This study suggested an increase in the risk of overall major congenital malformations for paroxetine as compared to other antidepressants [OR 2.2; 95% confidence interval, 1.34-3.63]. Healthcare professionals are advised to carefully weigh the potential risks and benefits of using paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients. See the FDA Web site for more information.
- On July 1, 2005, in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to update patients and healthcare providers with the latest information on this subject. Even before the publication of these recent reports, FDA had already begun the process of reviewing available data to determine whether there is an increased risk of suicidal behavior in adults taking antidepressants. The Agency has asked manufacturers to provide information from their trials using an approach similar to that used in the evaluation of the risk of suicidal behavior in the pediatric population taking antidepressants. This effort will involve hundreds of clinical trials and may take more than a year to complete. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Postnatal depression
- Puerperal psychosis

Note: It is important to distinguish postnatal depression from "baby blues", the brief episode of misery and tearfulness that affects at least half of all women following delivery, especially those having their first baby. It is also important that the term postnatal depression should not be used as a generic term for all mental illness following delivery.

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Nursing
Obstetrics and Gynecology
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To assist in screening, diagnosis, prevention and management of postnatal depression and puerperal psychosis
- To assist in the development of local evidence-based integrated care pathways

TARGET POPULATION

- Women throughout pregnancy and the first postnatal year
- Mothers diagnosed with depression or psychosis during the first postnatal year.

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis, Screening, and Prevention

1. Antenatal and postnatal risk factor assessment for postnatal depression and puerperal psychosis
2. Antenatal screening for postnatal depression and puerperal psychosis
3. Multidisciplinary postnatal depression screening (use of Edinburgh Postnatal Depression Scale [EPDS])
4. Prevention of postnatal depression through postnatal visits, interpersonal therapy, and/or antenatal therapy
5. Use of specialist psychiatric review to prevent puerperal psychosis in high-risk women (note: use of lithium prophylaxis in high-risk groups is considered but not recommended)

Management/Treatment

1. Pharmacological therapies
    - Tricyclic antidepressants
    - Selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, citalopram, paroxetine, and sertraline
    - Mood stabilisers (lithium; antiepileptic drugs such as valproate, carbamazepine, and lamotrigine)
    - Folic acid supplements
    - Therapies considered but not recommended: benzodiazepines, hormonal therapies, St. John´s Wort and alternative medicines
2. Psychotropic medications in pregnancy and lactation
3. Physical therapies (e.g., electroconvulsive therapy)
4. Psychosocial therapies
    - Counselling and psychotherapy
    - Social support
    - Family focused interventions
5. Mother and baby unit treatment options
6. Referrals to specialists
7. Patient and caregiver education

MAJOR OUTCOMES CONSIDERED

- Predictive value of screening tools and risk factor assessment for postnatal depression and puerperal psychosis
- Incidence of postnatal depression and puerperal psychosis
- Risk of fetal malformation, spontaneous abortion, and other fetal toxicity following drug exposure during pregnancy
- Perinatal problems, withdrawal symptoms, and impaired infant development following exposure to psychotropic drugs during pregnancy and lactation

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Literature searches were initially conducted in Medline, Embase, Cinahl, PsychLit, Healthstar, and the Cochrane Library using the year range 1991-2000. The literature search was updated with new material during the course of the guideline development process. Key websites on the Internet were also used, such as the National Guidelines Clearinghouse and the Marcé Society.

The literature search was then extended back to as far as was available in each of the databases and extra searches were supplied in areas such as complementary medicine and health economics. These searches were supplemented by the reference lists of relevant papers and group members´ own files. A lack of good evidence was identified by the searches, these results are similar to those of the Cochrane Library.

Overall, a total of 3,900 abstracts were identified by the literature searches, over 300 papers were assessed resulting in the final reference list of 171 papers.

NUMBER OF SOURCE DOCUMENTS

171

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++
High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+
Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1–
Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++
High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+
Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2–
Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3
Non-analytic studies, e.g. case reports, case series

4
Expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Scottish Intercollegiate Guidelines Network (SIGN) guidelines are developed by multidisciplinary groups using a standard methodology based on a systematic review of the evidence.

The Scottish Intercollegiate Guidelines Network (SIGN) carries out comprehensive systematic reviews of the literature using customized search strategies applied to a number of electronic databases and the Internet. This is often an iterative process whereby the guideline development group will carry out a search for existing guidelines and systematic reviews in the first instance and, after the results of this search have been evaluated, the questions driving the search may be redefined and focused before proceeding to identify lower levels of evidence.

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. SIGN has developed checklists to aid guideline developers to critically evaluate the methodology of different types of study design. The result of this assessment will affect the level of evidence allocated to the paper, which in turn will influence the grade of recommendation it supports.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site.)

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The process for synthesizing the evidence base to form graded guideline recommendations is illustrated in the companion document titled "SIGN 50: A Guideline Developer's Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN website.

Evidence tables should be compiled, summarizing all the validated studies identified from the systematic literature review relating to each key question. These evidence tables form an important part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

In order to address how the guideline developer was able to arrive at their recommendations given the evidence they had to base them on, SIGN has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups are expected to summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- Generalisability of study findings
- Applicability to the target population of the guideline
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources need to treat them.)

Guideline development groups are provided with a pro forma in which to record the main points from their considered judgement. Once they have considered these issues, the group are asked to summarise their view of the evidence and assign a level of evidence to it, before going on to derive a graded recommendation.

The assignment of a level of evidence should involve all those on a particular guideline development group or subgroup involved with reviewing the evidence in relation to each specific question. The allocation of the associated grade of recommendation should involve participation of all members of the guideline development group. Where the guideline development group is unable to agree a unanimous recommendation, the difference of opinion should be formally recorded and the reason for dissent noted.

The recommendation grading system is intended to place greater weight on the quality of the evidence supporting each recommendation, and to emphasise that the body of evidence should be considered as a whole, and not rely on a single study to support each recommendation. It is also intended to allow more weight to be given to recommendations supported by good quality observational studies where randomised controlled trials (RCTs) are not available for practical or ethical reasons. Through the considered judgement process guideline developers are also able to downgrade a recommendation where they think the evidence is not generalisable, not directly applicable to the target population, or for other reasons is perceived as being weaker than a simple evaluation of the methodology would suggest.

On occasion, there is an important practical point that the guideline developer may wish to emphasise but for which there is not, nor is their likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as "good practice points." It must be emphasized that

these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

Grade A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or randomized controlled trial rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rate as 2++

Grade D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A national open meeting is the main consultative phase of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group present their draft recommendations for the first time. The national open meeting for this guideline was held in June 2001 and was attended by all of the key specialties relevant to the guideline. The draft guideline

was also available on the SIGN web site for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

The guideline was reviewed in draft form by a panel of independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline.

The guideline was then reviewed by an Editorial Group comprising relevant specialty representatives on SIGN Council, to ensure that the peer reviewers´ comments had been addressed adequately and that any risk of bias in the guideline development process as a whole had been minimised.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

The strength of recommendation grading (A, B, C, D) and levels of evidence (1++, 1+, 1– , 2++, 2+, 2–, 3, 4) are repeated at the end of the "Major Recommendations" field.

Diagnosis, screening, and prevention

A: Procedures should be in place to ensure that all women are routinely assessed during the antenatal period for a history of depression.

D: All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis) and family history of affective psychosis.

C: The Edinburgh Postnatal Depression Scale (EPDS) should be offered to women in the postnatal period as part of a screening programme for postnatal depression.

C: The Edinburgh Postnatal Depression Scale is not a diagnostic tool. Diagnosis of postnatal depression requires clinical evaluation.

Management

B: Postnatal depression and puerperal psychosis should be treated.

D: Postnatal depression should be managed in the same way as depression at any other time, but with the additional considerations regarding the use of antidepressants when breast feeding and in pregnancy.

D: Puerperal psychosis should be managed in the same way as psychotic disorders at any other time, but with the additional considerations regarding the use of drug treatments when breast feeding and in pregnancy.

B: Psychosocial interventions should be considered when deciding on treatment options for a mother diagnosed as suffering from postnatal depression.

C: Interventions that work with more than one family member at a time should be considered when assessing the treatment options available.

D: The option to admit mother and baby together to a specialist unit should be available. Mothers and babies should not routinely be admitted to general psychiatric wards.

Prescribing Issues in Pregnancy and Lactation

B: The risks of stopping tricyclic or selective serotonin reuptake inhibitor (SSRI) antidepressant medication should be carefully assessed in relation to the mother´s mental state and previous history. There is no indication to stop tricyclic or SSRI antidepressant medication as a matter of routine in early pregnancy.

C: Where women with severe bipolar disorder are maintained on lithium, consideration should be given to continuing lithium during pregnancy if clinically indicated.

C: When a woman is maintained on lithium therapy, serum levels should be carefully monitored. Detailed fetal ultrasound scanning (level III) should be offered.

C: All women on antiepileptic drugs as mood stabilisers should be prescribed a daily dose of 5 milligrams (mg) folic acid from preconception until the end of the first trimester.

D: Valproate (valproic acid) should be avoided as a mood stabiliser in pregnancy.

B: Benzodiazepines should be avoided in the first trimester of pregnancy.

C: Neonates exposed to psychotropic medication during pregnancy should be monitored for withdrawal syndromes following delivery.

C: There is no clinical indication for women treated with tricyclic antidepressants (TCAs), other than doxepin, to stop breast feeding, provided the infant is healthy and its progress monitored.

C: There is no clinical indication for women treated with paroxetine, sertraline, or fluoxetine to stop breast feeding, provided the infant is healthy and his or her progress is monitored.

D: In view of the significant risks to the infant of a breast feeding mother taking lithium, mothers should be encouraged to avoid breast feeding. If a decision is

made to proceed, close monitoring of the infant, including serum lithium levels, should be provided.

D: New prescriptions for benzodiazepines should be avoided in mothers who are breast feeding. Note: this recommendation does not cover drug dependence, where breast feeding may be beneficial if the infant has been exposed to benzodiazepines in utero.

Definitions:

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A
At least one meta-analysis, systematic review of randomised controlled trials (RCTs); or RCT rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.

B
A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+.

C
A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++.

D
Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+.

Levels of Evidence

1++
High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias.

1+
Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.

1–
Meta-analyses, systematic reviews, or RCTs with a high risk of bias.

2++
High quality systematic reviews of case control or cohort studies.

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.

2+
Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.

2–
Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.

3
Non-analytic studies, e.g. case reports, case series.

4
Expert opinion

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see Major Recommendations).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Effective detection and adequate management of postnatal depression and puerperal psychosis
- Untreated postnatal depression may be prolonged and may have a deleterious effect on the relationship between mother and baby and on the child's cognitive and emotional development; however, evidence shows the responses to both pharmacological and psychosocial interventions is good.

POTENTIAL HARMS

Screening

Screening for postnatal depression can have negative consequences, particularly so in the field of mental health. It is therefore important that the health professionals administering any aspect of a screening programme are adequately trained to do so.

Psychotropic Drugs

Risks associated with psychotropic drugs in later pregnancy are neonatal toxicity or withdrawal syndrome following delivery and the possibility of a long term impact on the infant´s neurodevelopment.

Mood Stabilisers: Lithium

- Lithium is known to impair thyroid and renal function in adults.
- Newborn infants of women treated with lithium in later pregnancy face potential risks of neonatal toxicity, thyroid and renal dysfunction.

Mood Stabilisers: Antiepileptics

- Evidence from studies of women with epilepsy suggests that exposure to antiepileptic drugs in early pregnancy increases the risk of congenital malformations and this effect is related to the use of antiepileptic drugs, not the epilepsy.
- The relative risk is higher with valproate than carbamazepine and, in particular, with doses of valproate over 1000 milligrams per day; therefore, valproate should be avoided as a mood stabilizer in pregnancy.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) Trust and is an essential part of clinical governance. It is acknowledged that every Trust cannot implement every guideline immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Local implementation groups, consisting of representatives from the Health Board, acute and Primary Care Trusts, professionals, partner agencies (e.g., social services), the voluntary sector, and service users should be drawn together to consider the many strands which make up an effective, implementable service.

Refer to the original guideline for detailed information on integrated care pathways, key criteria for clinical audits, and resource implications.

IMPLEMENTATION TOOLS

Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Postnatal depression and puerperal psychosis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Jun. 28 p. (SIGN publication; no. 60). [171 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Jun

GUIDELINE DEVELOPER(S)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

Scottish Executive Health Department

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group: Mrs Patricia Purton (Chairman); Dr Roch Cantwell (Methodologist); Professor Beth Alder; Dr Barbara Ballinger; Dr Roddy Campbell; Ms Francesca Chappell; Mr Robert Crawford; Ms Vivienne Dickinson; Ms Tania Dignan; Ms Catriona Hendry; Dr Mary Hepburn; Ms Liz Kearney; Dr Eilis Kennedy; Dr Gerry McPartlin; Ms Evelyn McPhail; Ms Kim Milledge; Miss Christine Puckering; Mrs Marion Shawcross; Dr Imogen Stephens; Ms Joanne Topalian; Dr Sara Twaddle; Ms Jenny Williams; Mrs Noreen Wright

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development groups are required to complete a declaration of interests, both personal and non-personal. A personal interest involves payment to the individual concerned, e.g., consultancies or other fee-paid work commissioned by or shareholdings in the pharmaceutical industry; a non-personal interest involves payment which benefits any group, unit or department for which the individual is responsible, e.g., endowed fellowships or other pharmaceutical industry support. SIGN guideline group members should be able to act as independently of external commercial influences as possible, therefore, individuals who declare considerable personal interests may be asked to withdraw from the group. Details of the declarations of interest of any guideline development group member(s) are available from the SIGN executive.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline was issued in 2002 and will be kept under review as new evidence becomes available.

Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site:

- HTML Format
- Portable Document Format (PDF)

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Quick reference guide: Postnatal depression and puerperal psychosis. Edinburgh (UK): Scottish Intercollegiate Guidelines Network, 2002 Jun. 2 p.

Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

- SIGN 50: a guideline developers´ handbook. Edinburgh (UK): Scottish Intercollegiate Guidelines Network. (SIGN publication; no. 50). Available from the SIGN Web site.
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research and Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the SIGN Web site.
- A background paper on the legal implications of guidelines. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network.

PATIENT RESOURCES

The following is available:

- Information for patients and carers. In: Postnatal depression and puerperal psychosis. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2002 Jun. 28 p. (SIGN publication; no. 60).

Electronic copies: Available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site:

- HTML Format
- Portable Document Format (PDF)

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on February 21, 2003. The information was verified by the guideline developer on March 12, 2003. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine.

COPYRIGHT STATEMENT

Users wishing to use, reproduce, or republish SIGN material for commercial purposes must seek prior approval for reproduction in any medium. To do this, please contact sara.twaddle@nhs.net.

Additional copyright information is available on the SIGN Web site.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx.

NGC, AHRQ, and its contractor ECRI make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 5/15/2006